

# **EXHIBIT 1**

# Joel D. Edminster, MD, FACEP

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## EMPLOYER

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- 2008-Present *Providence Sacred Heart Medical Center & Providence Sacred Heart Children's Hospital*
- 644-bed nonprofit, Catholic hospital, sponsored by the Sisters of Providence
  - Serving the region from the Cascades to Eastern Montana, Southern BC to Northern Oregon
  - Tertiary Care Center with Level II Trauma Designation
  - JAHCO Certified Primary Stroke Center
  - Academic Institution affiliated with UW School of Medicine
- 2008 - Present *Spokane Emergency Physicians*
- Independent group employing 40 fulltime and part time physicians
  - Providing Staff for both Pediatric & Adult Emergency Departments
  - 23 % of adult ED patients admitted (21% overall)
  - Providing academic opportunities for multiple residency programs statewide and Students from UW School of Medicine
  - Elected to Executive Committee consecutive terms 2010-2014

## EDUCATION

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- 2005-2008 *MetroHealth Medical Center/Cleveland Clinic Foundation Emergency Medicine Residency Program - Cleveland, Ohio*
- MetroHealth Medical Center ED treats > 90,000 patients annually
    - Level 1 Trauma Center with Pediatric Commitment
    - Level 1 Burn Center
    - JCAHO Primary Stroke Center
  - Cleveland Clinic Foundation ED treats > 65, 000 patients
    - Rated #1 13 straight years for cardiac care, *US News & World Report*
    - JCAHO Primary Stroke Center

- 2001-2005      *Case Western Reserve University- School of Medicine*  
Cleveland, OH
- Doctor of Medicine
- 1996-2001      *Carroll College - Helena, MT*
- Bachelor of Arts – Graduation with Honors – *Cum Laude*
    - Biology & Psychology

## EMS EXPERIENCE

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- 2016 – Present    Medical Director  
Spokane County Fire Dist#9
- BLS & ALS Agency
  - Serving the Citizens of the City of Spokane, Mead & Colbert
  - Administrative responsibilities including quality assurance measures and EMS education.
- 2014 – Present    Medical Director  
Spokane City Fire Department
- BLS & ALS Agency
  - Serving the Citizens of the City of Spokane
  - Administrative responsibilities including quality assurance measures and EMS education.
- 2014-Present    Medical Director  
Spokane Valley Fire Department
- BLS & ALS Agency
  - Serving the Citizens of Spokane Valley & Liberty Lake
  - Administrative responsibilities including quality assurance measures and EMS education.
- 2012 - 2017      Medical Director  
INHS HTN Paramedic Program
- 1,508 hour, three-quarter time program leads to certification as a Paramedic in the State of Washington and the National Registry of EMTs.
  - U.S. Department of Transportation, National Highway Traffic Safety Administration 2009 Paramedic Curriculum
  - CoAEMSP Accredited

- 2010 - 2014      **Medical Director**  
**Deer Park Ambulance**
- BLS, ILS, & ALS Agency
  - Non-profit, private agency serving approximately 600 square miles in Spokane & Stevens County
  - Administrative responsibilities including quality assurance measures and EMS education.
- 2010 - 2014      **Medical Director**  
**Spokane County Fire District #4**
- Established in 1945, the district to serves over 330 square miles of North Spokane County
  - 170 member volunteer Firefighters, 25 plus Part-Time Paid Firefighters, 13 career staff/officers
  - Administrative responsibilities including quality assurance measures and EMS education.
- 2007-2008      **Flight Physician**
- Primary physician on the nationally recognized critical care transport service LifeFlight with 3,500 flights annually.
  - Flights include inter-hospital transport of critically ill patients and trauma scene transport for adult and pediatric patients.
  - Flight team consists of physician, critical care nurse, and 2 pilots on Sikorsky S-76 rotor wing aircraft.

## **ACADEMIC WORK EXPERIENCE**

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- 2008 - Present      **Resident & Medical Student Clinical Instructor**
- J. Floyd School of Medicine, WSU – Medical Students
  - UW School of Medicine – Medical Students
  - Sacred Heart Transitional Year Residency
  - Internal Medicine Residency of Spokane (UW Affiliate)
  - Family Medicine Residency of Spokane (UW affiliate)
- 2007-2008      **Chief Resident**
- Administrative responsibilities including participation in the Resident Steering Committee, scheduling, quality assurance measures and conflict resolution.
  - Resident education responsibilities including regular didactic sessions, organization of resident lectures and literature review for, and the management of the resident website.

## RESEARCH & PUBLICATIONS

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- Evaluation of Physiologic Alterations During Prehospital Paramedic –Performed Rapid Sequence Intubation
  - Prehospital Emergency Care.
  - May-June 2018;22(3):300-311
- EMS & Schools for Cardiac Arrest Survival - 2013
  - 2-day Program with video didactic & hands-on training in bystander CPR & AED use
  - Pairing Local EMS agencies with public schools for CPR training
- *ABCD Score in TIA* –validation study of a published TIA “score” in an effort to determine its utility as a decision making tool in the ED setting – no publication.
  - Presented at Midwest ACEP 2006
  - Presented at International Stroke conference – San Francisco 2007
- *Ohio Burden of Stroke Study* – State wide, CDC funded study involving pre-hospital stroke education for rural EMS departments in an effort to improve run times and improve time to definitive therapy.

## CERTIFICATIONS

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- Fellow of the American College of Emergency Physicians
- Board Certified in Emergency Medicine (ABEM)
- Washington State Medical License
- Certified in Ultrasound for FAST, renal, gallbladder, aorta and 1<sup>st</sup> trimester OB

## PROFESSIONAL MEMBERSHIPS

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- Diplomate American Board of Emergency Medicine
- American College of Emergency Physicians (ACEP)
- National Association of EMS Physicians (NAEMSP)
- Spokane County EMS Council
- Spokane County EMS QI/QA Committee
- Washington State Disaster Medical Advisory Committee
- Spokane Disaster Clinical Advisory Committee
- Spokane County EMS Podcast - Host

## **EXHIBIT 2**

September 23, 2021

**Medical Director Recommendation**

Re: Vaccination against SARS-CoV-2

The COVID-19 pandemic has caused unprecedented disruption. Each of us has sacrificed in our efforts to try to serve patients and to support community health. And yet, we are still challenged by the COVID-19 pandemic. Despite ongoing extraordinary efforts, persons continue to die from this infection in King County. Moreover, the resources needed to care for patients with COVID-19 has led to deferred treatment for many with serious medical needs unrelated to COVID-19, a reality that also produces adverse health outcomes.

The public health toll is unacceptable especially given that we have effective tools to prevent SARS-CoV-2 infection. Our pledge to protect and serve our patients requires that we commit to the safest, most effective strategy to control and overcome the pandemic. This is our responsibility as public servants and health leaders. The approach requires that we employ all methods to include social distancing, appropriate personal protective equipment, testing, and vaccination. Social distancing, PPE, and testing are useful strategies that supplement, but do not circumvent, the cornerstone therapy of vaccination against SARS-CoV-2. A strategy that employs all these tools provides safety for the individual EMS provider, their colleagues, patients, and the larger public.

Our recommendation as Medical Program Directors for Seattle and King County EMS is that EMS agencies require full vaccination against SARS-CoV-2 in order to provide direct patient care. Consequently, we appreciate that accommodations need to be individualized but providing direct patient care when not fully vaccinated may compromise workplace safety and put vulnerable patients at risk.

We recommend that you notify employees that they may make requests for a reasonable accommodation based on a medical disability or for sincerely held religious beliefs. Your agency should determine if the employee is eligible to be considered for an accommodation and engage in an interactive process before making the determination. After the eligibility decision, you should determine if the employee can be *safely* accommodated given the unique elements of the law, their job and work options, understanding that there are likely limited options for accommodations and you may not be able to accommodate all requests. Examples of an undue burden for the purpose of accommodating a sincerely held religious belief include if the accommodation is costly, infringes on other employees' job rights or benefits, compromises workplace safety, decreases workplace efficiency, or requires other employees to do more than their share of potentially hazardous or burdensome work.

When a patient calls 9-1-1 for a medical emergency, they often have no other option for health care – 9-1-1 is their only recourse – EMS cannot pick and choose who and how to respond. We must serve our patients and the community in a manner that achieves the highest level of safety for all. EMS providers in King County are leaders in emergency care who repeatedly make important sacrifices to serve those around them. We must do our best to deliver safe and effective health care, a commitment and pledge that requires vaccination against SARS-CoV-2.

Respectfully,

Thomas Rea MD MPH  
Medical Program Director  
Emergency Medical Services Division  
Public Health – Seattle & King County

Michael Sayre MD  
Medical Director  
Seattle Fire Department



# **EXHIBIT 3**

# **Spokane Regional EMS**

## **COVID-19 Medical Group Recommendations**

Dr. Bob Lutz – Spokane Regional Health Officer  
Dr. James Nania – Spokane County EMS Medical Program Director

April 9, 2020

# Updates

## April 9, 2020

- **Corrected bleach disinfection concentration**
- **Added “Universal precautions” language to dispatch protocol**
- **Added warning against the use of alcohol and chlorine-based disinfection methods on N95 respirators**
- **Due to the CDC’s Level 3 travel warning, members returning from ANY international travel are considered a travel exposure**
- **Added hospital alert language: “Advanced Isolation Procedures” communicates to the destination hospital that the patient requires increased precautions for an infectious disease**
- **Additional clarification for discontinuing SVN and CPAP before transferring from the ambulance to the emergency department room in the “Airway Management” section**

March 30, 2020

- Clarified Echo response language
- Added language to “Airway management” section recommending “if a high risk procedure is anticipated or performed, all EMS providers need to use an N95 regardless of distance from the patient. Aerosol spread distance is not well known at this time.”
- Added updated COVID-19 screening questions and quick reference guide
- Added point of contact recommendations

March 25, 2020

- Updated Full Staffing Plan guidelines and flowchart
- Updated Alternate Staffing Plan guidelines and flowchart
- Removal of the return to work flowchart
- Added potential “stay-at-home” pandemic triage guidelines from the Spokane County EMS & Trauma Care Council
- Added Spokane Regional Health District recommendations for return to work following positive COVID-19 test

March 23, 2020

- Updated quarantine location language
- Added recommended response PPE level chart
- Updated dispatch information regarding the removal of the 36 Pandemic criteria

March 22, 2020

- Updated return to work guidelines
- Updated CPR PPE guidelines.
- Added proper cleaning and disinfecting procedures for linen and cloth based products.
- Added clarification to the proper time to use an N95 mask and how to properly store for multiple uses.
- Updated reporting requirements and added ESO walkthrough to help properly record and track COVID-19 responses and PPE use.

March 19, 2020

- Clarified advanced airway management section. Bag-valve ventilation is performed after successful intubation, as normal, with the use of an inline HEPA filter, if available. Also, added clarity in distinguishing acute exacerbations of chronic conditions such as CHF, COPD, and asthma from new onset symptoms consistent with COVID-19.
- Safety 1 is no longer added to 36 Pandemic responses.

March 18, 2020

## COVID-19 Response Recommendations

- Added clarification of SVN and CPAP recommendations the recommendation to discontinue SVN treatment and place a mask on the patient prior to entering the emergency department in the “Special considerations regarding airway management” section.
- Clarified language and added “subjective symptoms of fever” to the pre-shift screening / self-screening criteria, and the exposure definition of symptomatic member.
- Updated current dispatch instructions for 36 Pandemic Disease responses to include “have the patient meet EMS at the threshold of the front door” when they arrive.
- Added “Cleaning and Disinfecting Procedures” section.
- Added the ability to document specific PPE use for each responder in ESO under “Personnel”.
- Updated return-to-work requirement for symptomatic members to include facemask use upon return.
- Added “Quarantine and Isolation Recommendations.”
- Inclusion of supplemental material: Exposure flowchart, Return-to-work flowchart, PPE guidelines, Thermometer best practices.

## COVID-19 Overview

### What is a Novel Coronavirus?<sup>1</sup>

A novel coronavirus is a new coronavirus that has not been previously identified. The virus causing coronavirus disease 2019 (COVID-19), is not the same as the coronaviruses that commonly circulate among humans and cause mild illness, like the common cold.

A diagnosis with coronavirus 229E, NL63, OC43, or HKU1 is not the same as a COVID-19 diagnosis. Patients with COVID-19 will be evaluated and cared for differently than patients with common coronavirus diagnosis.

### What is the Source of the Virus?

Coronaviruses are a large family of viruses. Some cause illness in people, and others, such as canine and feline coronaviruses, only infect animals. Rarely, animal coronaviruses that infect animals have emerged to infect people and can spread between people. This is suspected to have occurred for the virus that causes COVID-19. Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) are two other examples of coronaviruses that originated from animals and then spread to people. More information about the source and spread of COVID-19 is available on the Situation Summary: Source and Spread of the Virus.

### How Does the Virus Spread?

Early reports suggest person-to-person transmission most commonly happens during close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs or sneezes. Droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity. The contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission is currently uncertain. However, airborne transmission from person-to-person over long distances is unlikely.<sup>2</sup>

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<sup>1</sup> <https://www.cdc.gov/coronavirus/2019-ncov/faq.html>

<sup>2</sup> [https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html](https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html)

## When is Someone Infectious?

The onset and duration of viral shedding and period of infectiousness for COVID-19 are not yet known. It is possible that SARS-CoV-2 RNA may be detectable in the upper or lower respiratory tract for weeks after illness onset, similar to infection with MERS-CoV and SARS-CoV.

However, detection of viral RNA does not necessarily mean that infectious virus is present. Asymptomatic infection with SARS-CoV-2 has been reported, but it is not yet known what role asymptomatic infection plays in transmission. Similarly, the role of pre-symptomatic transmission (infection detection during the incubation period prior to illness onset) is unknown. Existing literature regarding SARS-CoV-2 and other coronaviruses (e.g. MERS-CoV, SARS-CoV) suggest that the incubation period may range from 2–14 days.

## What are the symptoms of COVID-19?

Common signs of infection include respiratory symptoms, fever, and cough, shortness of breath and breathing difficulties. In more severe cases, infection can cause pneumonia, severe acute respiratory syndrome, kidney failure and even death. Reported illnesses have ranged from mild symptoms to severe illness and death for confirmed coronavirus disease 2019 (COVID-19) cases. The following symptoms *may appear 2-14 days after exposure*: fever, cough, and/or shortness of breath.

## How is COVID-19 different from the Flu?

Although the two illnesses appear similar, they are caused by two different viruses. While there are vaccines for the flu, based on the particular strains of influenza prevalent for that season, there is no current vaccine or anti-viral medication found to be effective against COVID-19. The COVID-19 situation is changing rapidly. Since this disease is caused by a new virus, people do not have immunity to it, and a vaccine may be many months away. Doctors and scientists are working on estimating the mortality rate of COVID-19, but at present, it is thought to be higher than that of most strains of the flu.<sup>3</sup>

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<sup>3</sup> (Centers for Disease Control and Prevention, n.d.) (World Health Organization, n.d.) (Johns Hopkins Medicine, n.d.)

## Definitions

**Prolonged exposure:** Generally greater than 10 minutes. Clinical symptoms of patient and type of interaction remain important. (e.g., did the patient cough directly into the face of the EMS provider)

**Close contact:** Person being within 6 feet of a COVID-19 case for a prolonged period of time or unprotected direct contact with secretions or excretions.

**Non-work exposure:** When a member is exposed in a non-work setting to a person under investigation (PUI) or a person with a positive COVID-19 test.

**Fever:** Temperature  $\geq 100.0^{\circ}\text{F}$  or subjective fever. Note that temperature may be intermittent or may not be present in some patients. (e.g., elderly, immunocompromised or those taking NSAIDs)

**Self-monitoring:** EMS provider should monitor themselves twice daily for fever and remain alert for symptoms of acute respiratory infection.

**Respirator:** A personal protective device that covers at least nose and mouth; N95/N100.

**Facemask:** A mask that covers at least the nose and mouth and helps block respiratory secretions.

**Person under investigation:** A person presenting with signs and symptoms as follows:

- Temperature  $100.0^{\circ}\text{F}$ ; or subjective symptoms of fever.
- Symptoms of acute respiratory illness (cough, difficulty breathing, sore throat); or
- Having prolonged close contact with a person under investigation or a positive COVID-19 case who was not wearing the recommended PPE.<sup>4</sup>

**POC:** Point of contact. This can be a single person or an entire team, depending on the needs of the organization. A single point of contact helps streamline communication between members and the organization.

**Hotline:** A 24/7 staffed phone number which can assist members who become sick, or answer questions regarding exposures.

**Advanced Isolation Procedure:** Term used to communicate to the destination hospital that the patient requires increased precautions for an infectious disease.

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<sup>4</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>

## Pre-Response

### Pre-Shift Screening

All personnel should assess their temperature at the start of shift and every 12 hours thereafter. A temperature over 100.0° F, subjective symptoms of fever, or the presence of a cough, sore throat, or respiratory symptoms such as shortness of breath categorizes the individual as a person under investigation (PUI). The member will need to initiate quarantine procedures.<sup>5</sup>

All personnel are encouraged and may be required as per directives from individual agencies to wear a facemask at all times while in firehouses and spaces where co-habitation is required for daily operations (please refer to guidance on reuse of facemask).

### Station and Apparatus Cleaning

Daily: Along with regular station and apparatus cleaning, a focused daily sanitization of commonly touched surfaces needs to occur.

### Social Distancing

The fire department is a place where we work and socialize with our department family. During this epidemic we need to work to modify our interactions and practices. The CDC recommends keeping a 6 foot distance from others. This may be impractical in the fire station and impossible on most apparatus. What we can do instead is try to take thoughtful steps to limit the chance of a virus spreading among our work family. Here is a list of suggestions as a starting point.

1. Avoid congregating at the kitchen table, especially at shift change when there is a denser population at the station.
2. Attempt to increase spacing between personnel at mealtime, such as sitting in alternate chairs.
3. Attempt to minimize close contact with department personnel outside your fire company or work group.
4. Avoid foods that involve many hands reaching into a shared container (for example, potato chips) or find a way of serving that limits cross contamination.
5. Wipe frequently touched surfaces down regularly.
6. Wash hands frequently.
7. Fewer high-fives, more elbow-bumps.
8. Use your discretion and judgement to make our workplaces as safe as possible.

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<sup>5</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>



## Dispatch

Dispatch is recommended to continue interrogating callers as usual. There will be increased awareness around the 26 General Sick criteria, with the following triggers identified as suspected COVID patients:

1. Flu-like symptoms, such as a fever, cough, shortness of breath, sore throat, runny nose, fatigue, or feeling generally ill.

**OR**

2. The patient has had close contact to an individual who is known to have tested positive for COVID-19.

If Dispatch identifies a patient who meets the above criteria, they will attempt to instruct the patient to meet EMS at the threshold of their front door when they arrive. They will continue to add notes and advise crews of pertinent patient history, as available.

The 36 Pandemic Flu dispatch criteria is designed to be used to identify an emerging pandemic flu and relies heavily on travel information and contact with individuals with a known infectious disease. Based on our experience to this point, COVID-19 is at a level of prevalence in the community which requires less stringent criteria to be considered a potential hazard to crews. Therefore, the 36 Pandemic flu response code will be discontinued as it is no longer meeting the necessary requirements to identify potential COVID-19 patients.

When responding to a suspected COVID-19 patient, dispatch will notify crews within the dispatch notes and via pagers with "Potential COVID-19 Patient" and by verbally stating "Use Universal Precautions" in the short report update.

*Please increase your suspicion of COVID-19 in the community to patients with any of the following symptoms: flu-like symptoms, such as a fever, cough, shortness of breath, sore throat, runny nose, fatigue, or feeling generally ill.*

## EMS Response

### All EMS Responses:

1. PPE minimum for all providers:
  - Gloves
  - Standard eye protection
  - Facemask for anyone with patient contact
2. If possible, perform a single provider door triage / room scan / 6 ft of separation. When practical maintain contact with crew members. Use caution if a crew member is operating alone, beyond the line of sight.
3. Screen for COVID-19 risk criteria:
  - Has the patient experienced a fever or respiratory symptoms (cough, dyspnea, etc) in the last 72 hours?

**OR**

  - Has the patient had close contact with a COVID-19-confirmed patient or a patient under testing for COVID-19?
4. If patient screens positive for COVID-19 risk criteria, consider them a suspected COVID-19 patient and increase PPE level, if needed.
5. Perform source control on all patients who have experienced respiratory symptoms or fever in the last 72 hours by placing a facemask on the patient.
  - Nasal cannula can be placed underneath the facemask
  - An oxygen mask can substitute for a mask in patients requiring oxygen concentrations greater than 6 lpm
6. Encourage standard infection control measures throughout the patient encounter.

**These are minimum PPE recommendations. EMS providers may increase their level of PPE based on their discretion and patient presentation.**

## COVID-19 Screening Questions for EMS Providers:

Screening questions to be asked on **ALL** calls during initial patient interview, while staying >6ft away, if possible:

1. Do you have a fever?
2. Do you have any symptoms of a fever such as body aches or chills?
3. Do you have a sore throat, cough, and/or difficulty breathing?
4. Does anyone here have any of the symptoms I have just asked about?
5. Is anyone here under quarantine for any reason?

If yes to **ANY** of these, if there is a language barrier, or if the patient is unconscious, then facemask, standard eye protection, faceshield (or goggles), gloves, and gown (or Level B PPE) must be worn, at a minimum.

If they feel it is appropriate, a provider may switch to an N95 at their discretion, so long as it is safe to do so.

### **If in doubt, err on the side of caution and use an N95**

If there is a potential for a high risk procedure: gloves, standard eye protection, faceshield (or goggles), gown (or Level B PPE), and an **N95** must be worn by **ALL** personnel. High risk procedures include: BVM, CPAP, SVN, intubation, and suctioning.

## **EMS Response to suspected or known COVID-19 Patients (Positive Screening from Dispatch or Initial History):**

1. Throughout the encounter, take steps to limit the number of personnel in contact with the patient.
  - Only those providers working in close proximity (<6ft) with the suspected COVID-19 patient are required to don the higher level PPE; gloves, facemask or N95, standard eye protection, faceshield (or goggles<sup>6</sup>) and gown (or Level B PPE).
  - All other providers should maintain appropriate separation AND continue to wear the minimum level of PPE if potential for patient contact exists.
2. If possible, apply a facemask to the patient for source control.
  - A nasal cannula can be applied underneath the facemask
  - An oxygen mask can substitute for a facemask in patients requiring oxygen concentrations greater than 6 lpm
3. PPE minimum for standard encounter with suspected COVID-19 patient:
  - Gloves
  - Standard eye protection with faceshield (or goggles)
  - Facemask or N95 respirator (or greater)
  - Gown or level B PPE
4. PPE minimum for high risk encounter<sup>7</sup> with suspected COVID-19 patient:
  - Gloves
  - Standard eye protection with faceshield (or goggles)
  - N95 respirator (or greater)
  - Gown or level B PPE

**These are minimum PPE recommendations. EMS providers may increase their level of PPE based on their discretion and patient presentation.**

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<sup>6</sup> Goggles may be worn in place of standard eye protection with face shield. PPE type and availability will vary based on agency.

<sup>7</sup> High risk encounters include procedures likely to generate higher concentrations of respiratory secretions or aerosols, including cardiopulmonary resuscitation, BVM, intubation, CPAP, SVN, suctioning, etc. If a high risk procedure is anticipated or performed, all EMS providers need to use an N95 regardless of distance from the patient. Aerosol spread distance is not well known at this time.

## Airway Management:

Special considerations regarding airway management for confirmed or suspected COVID-19 patients\*:

- Providers treating any patient requiring airway management, or participating in high risk procedures that generate aerosols, must be in the highest level of PPE including N95 respirator (or greater)<sup>8</sup>. This level of PPE must be established prior to beginning any high risk procedure.
- Avoid nasal cannula concentrations higher than 6 lpm.
- Avoid small volume nebulizer (SVN) use, if patient condition allows, in favor of patient supplied metered dose inhalers (MDI) for albuterol or atrovent administration.
- Aerosol generating procedures such as nebulizer treatments and CPAP should be discontinued before moving the patient from the ambulance to the hospital room. Receiving hospital staff should be consulted prior to restarting these aerosol generating procedures.
- Avoid the use of CPAP. Consider delaying advanced airway management procedures to definitive destination, if patient condition allows. If respiratory failure is imminent, proceed to RSI.
- Endotracheal intubation should be performed by the provider most experienced in airway management, if practical.
- Intubation should be performed as a “rapid sequence induction.” BVM should not be used during preoxygenation or the intubation procedure. A nonrebreather should be utilized for preoxygenation, followed by induction and paralysis. Following successful intubation, bag-valve ventilation should be performed as normal.
- Intubation with video laryngoscopy is preferred in order to increase provider-patient distance.
- If available, an inline HEPA filter should be utilized when ventilating via bag-valve.
- If a high risk procedure is anticipated or performed, all EMS providers need to use an N95 regardless of distance from the patient. Aerosol spread distance is not well known at this time.

*\* The definition of suspected COVID-19 patients will change based on the prevalence of the disease in our community. Please use provider judgement as your best determinant for distinguishing acute exacerbations of chronic conditions such as CHF, COPD, and asthma from new onset symptoms consistent with COVID-19.*

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<sup>8</sup> High risk encounters include procedures likely to generate higher concentrations of respiratory secretions or aerosols, including cardiopulmonary resuscitation, BVM, intubation, CPAP, nebulizer therapy, suctioning, etc.

## Hospital Alert Language

Suspected or known COVID-19 patients must have appropriate infection control precautions in place prior to arrival at the Emergency Department. This information should be included in the initial communication with the destination hospital. During communication with the destination hospital, either by telephone or radio, EMS will provide all standard patient information and state that **ADVANCED ISOLATION PROCEDURES** need to be taken.

When caring for a patient with a high degree of suspicion for COVID-19, EMS providers should take appropriate steps to minimize exposure risk while transferring the patient into the hospital. EMS should ensure source control is applied to the patient with either a facemask or nonrebreather (NRB) mask, depending on oxygen needs. Aerosol generating procedures such as nebulizer treatments and CPAP should be discontinued before moving the patient from the ambulance to the hospital room. Receiving hospital staff should be consulted prior to restarting these aerosol generating procedures.

## CPR Guidelines: Active Echo Call with CPR

Initial minimum required PPE while responding to Cardiac Arrest:

- Gloves
- N95
- Standard eye protection
- Faceshield (or goggles<sup>9</sup>)
- Gown (or Level B PPE)

“Level Red” PPE should be worn until an appropriate medical screening can be completed and patient’s risk for COVID-19 can be assessed.

If responders are able to determine that COVID-19 is not suspected or known, they may reduce the level of PPE at their discretion.

*Gloves, standard eye protection, and facemask are always required.*

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<sup>9</sup> Goggles may be worn in place of standard eye protection with faceshield. PPE type and availability will vary based on agency.

## **Gown-Donning Procedure**

Remember MEGG:

**Mask:**

1. Place mask on face and hold on nose with finger
2. Place top strap behind head above ears
3. Place lower strap behind head below ears
4. Use both hands to tighten straps
5. Form mask to bridge of nose
6. Ensure seal and retighten as necessary

**Eyes:** put on standard eye protection with addition of faceshield (or goggles) for suspected COVID-19 patients

**Gown:** Put on gown, tying in back

**Gloves:** Put gloves on, ensuring gloves cover sleeves of gown

## **Gown-Doffing Procedure**

Remember GGEM (reverse of donning):

1. The goal of doffing is to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious material.
2. Visually inspect for gross contamination.
3. **Gown:** Remove gown and gloves by grasping the gown with gloved hands and pulling away from your body, rolling the gown inside-out into a bundle.
4. **Gloves:** Remove gloves, inside-out. Dispose of glove and gown in waste container.
5. **Eyes:** Remove face shield (or goggles) and standard eye protection.
6. **Mask:** Remove mask or respirator.
7. Wash hands or use alcohol-based hand sanitizer.

## **Use of Level B PPE in Lieu of Gown**

If gowns are unavailable, Level B jacket and pants can be substituted.

### **Donning of Level B jacket and pants:**

1. Take black and yellow tub off apparatus:
  - i. Empty contents of tub.
  - ii. Place tub in a suitable decon/doffing location.
  - iii. Place garbage bag and Red Bag near tub.
  - iv. Place disinfectant spray bottle and wipes near tub.
2. Put Level B pants on, over your station uniform.
3. Put Level B jacket on.
4. Put on facemask or N95 respirator, as appropriate.
5. Put on standard eye protection and faceshield (or goggles)
6. Put on gloves.
7. Care for patient.

### **Doffing of Level B jacket and pants:**

1. Move to Doffing area.
2. Place non-disposable medical equipment in an area away from doffing location for 2nd crewmember to disinfect.
3. Without touching inside of jacket, remove jacket:
  - i. Use 2nd crewmember if needed.
  - ii. Place jacket in garbage bag for later decon.
4. Remove level B pants:
  - i. Undo buckles.
  - ii. Remove pants without touching inside of pants.
  - iii. Place in garbage bag for later decon.
5. Remove gloves.
6. Remove faceshield or goggles:
  - i. If disposable, place in red bag.
  - ii. If reusable, place in garbage bag for later decon.
7. Remove facemask or N95 respirator and place in red bag.
8. Wash hands or use alcohol-based hand sanitizer.



## Facemask/N95 Respirator Reuse:

1. Reuse of facemasks is acceptable and the mask can be stored on or with the provider between incidents.
  - a. **Note:** Gross contamination or damage to the mask warrants replacement.
2. **DO NOT** use alcohol and chlorine-based disinfection methods. Evidence indicates these chemicals will remove the static charge in the microfibers of N95 respirators, reducing filtration efficiency. In addition, chlorine also retains gas after decontamination and these fumes may be harmful.
3. Reuse of N95 respirators is acceptable following patient care that has not generated high concentrations of respiratory secretions or aerosols.
  - i. Gross contamination or damage to the N95 warrants replacement.
  - ii. Dispose of N95 respirators after high risk encounters.
  - iii. Storage should be in a closed container which does not compromise the shape of the mask and provides for ventilation (e.g., perforated plastic container or paper bag).
  - iv. N95 respirators should be limited to 5 reuses or 8-hours of continuous use.

**Note:** A use-count system can be helpful, such as marking a piece of tape on the storage container.
4. If perforated plastic containers are used for N95 storage, personnel should disinfect the inside of the container, allowing for appropriate dry time prior to storing the N95.<sup>10</sup>

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<sup>10</sup> <https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html>

## Cleaning and Disinfecting Procedures

The following are general guidelines for cleaning and disinfecting EMS equipment after treating a suspected or known COVID-19 patient:

- If possible, members should attempt to clean and disinfect equipment on scene, prior to storing equipment back on an apparatus.
- When cleaning and disinfecting equipment, it is recommended to perform this task outside, away from concentrated, potentially infectious particles inside a patient's initial contact setting or treatment area.
- When cleaning and disinfecting equipment used during patient care of a suspected COVID-19 patient, members shall wear gloves, facemask, standard eye protection, faceshield (or goggles), and gown.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly, to include the provision of adequate ventilation when chemicals are in use.
- All surfaces that may have come in contact with the patient or materials contaminated during patient care (e.g., stretcher, rails, control panels, floors, walls, work surfaces) should be thoroughly cleaned and disinfected using an EPA-registered hospital grade disinfectant in accordance with the product label.
- Clean and disinfect reusable patient-care equipment before use on another patient, according to manufacturer's instructions.
- Follow standard operating procedures for the containment and disposal of used PPE and regulated medical waste.
- Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2 (COVID-19)<sup>11,12</sup>

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<sup>11</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html>

<sup>12</sup> <https://www.cdc.gov/infectioncontrol/guidelines/disinfection/disinfection-methods/chemical.html>

## Current Recommended Disinfecting Products

### 1. Clorox® Disinfecting Wipes:<sup>13</sup>

- Wipe surface to be disinfected.
- Keep surface wet for 4 minutes.
- Let surface dry.
- For highly soiled surfaces, clean excess dirt first.
- For items that come in contact with food or mouths rinse with warm water and let air-dry.



### 2. Bleach:<sup>14</sup>

- Prepare a bleach solution using one of the following mixes:
  - 1/3 cup (79 ml) bleach per gallon of water

**OR**

- 4 teaspoons (20 ml) bleach per quart of water
- Pre-wash surface.
- Mop or wipe with a bleach solution.
- Allow solution to contact the surface for 5 minutes.
- Rinse with warm water and let air-dry.



**Note:** Bleach solutions in tap water at a pH >8 stored at room temperature (23°C) in closed, opaque plastic containers can lose up to 40%–50% of their free available chlorine level over one month.<sup>15</sup>

<sup>13</sup> <https://www.clorox.com/how-to/disinfecting-sanitizing/cold-flu-other-diseases/help-prevent-the-spread-of-the-human-novel-coronavirus-2019-ncov/>

<sup>14</sup> <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cleaning-disinfection.html>

<sup>15</sup> <https://www.cdc.gov/infectioncontrol/guidelines/disinfection/disinfection-methods/chemical.html>

**3. Sani-Cloth® Plus Germicidal Disposable Cloth:<sup>16</sup>**

- Wipe surface to be disinfected.
- Keep surface wet for 4 minutes.
- Let surface dry.
- For highly soiled surfaces, clean excess dirt first.
- For items that come in contact with food or mouths rinse with warm water and let air-dry.



**Note:** If disinfectant product to be used is not listed here:

Current guidelines recommend an approved EPA-registered disinfectant that has qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2 as listed in List N: Disinfectants for Use Against SARS-CoV-2.<sup>17</sup> Follow manufacturer's recommendations when using.

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<sup>16</sup> <https://pdihc.com/products/environment-of-care/sani-cloth-plus-germicidal-disposable-cloth/>

<sup>17</sup> <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>

## Cleaning and Disinfecting Clothing, Towels, Linens, and other Laundered Items

The following are general guidelines for cleaning and disinfecting re-usable facemasks, clothing, towels, linens, and other cloth items after they come into contact with a suspected COVID-19 patient:

- Members with a suspicion of gross uniform contamination or obvious particulate exposure, following a high risk encounter with a suspected COVID-19 patient, should follow the on scene doffing procedure, don clean clothing on scene, and immediately wash contaminated clothing after returning to the station.
- When cleaning and disinfecting cloth-based items, it is recommended that members wear disposable gloves.
  - If using reusable gloves, those gloves should be dedicated for cleaning and disinfection of surfaces for COVID-19 and should not be used for other household purposes. Wash hands immediately after gloves are removed.
  - If no gloves are used when handling dirty laundry, be sure to wash hands thoroughly afterwards.
- If possible, do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
- It is recommended that members launder items as appropriate in accordance with the manufacturer's instructions.
  - If possible, launder items using the warmest appropriate water setting for the items and dry items completely. Dirty laundry from an ill person can be washed with other people's items.
  - Recent research has shown that the virus can be killed with a combination of heat and time:
    - 90 minutes at 132° F, 60 minutes at 152° F, or 30 minutes at 167° F <sup>18</sup>
- Clean and disinfect clothes hampers according to guidance above for surfaces. If possible, consider placing a bag liner that is either disposable (can be thrown away) or can be laundered.<sup>19,20</sup>

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<sup>18</sup> <https://pubmed.ncbi.nlm.nih.gov/14631830/>

<sup>19</sup> [https://www.cdc.gov/coronavirus/2019-ncov/prepare/cleaning-disinfection.html?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcommunity%2Fhome%2Fcleaning-disinfection.html](https://www.cdc.gov/coronavirus/2019-ncov/prepare/cleaning-disinfection.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcommunity%2Fhome%2Fcleaning-disinfection.html)

<sup>20</sup> <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>

## SCBA Regulator Disinfecting Procedures

### Disinfecting procedures for the SCOTT regulator:

*This procedure has been recommended by SCOTT, and may not be appropriate for all SCBA devices. Please refer to your manufacturer's recommendations and department protocols for proper cleaning details.*

Per manufacturer's recommendations, all personnel shall regularly disinfect the shared SCOTT SCBA regulators to reduce potential for spreading colds and viruses during morning checks and operational use.

SCOTT recommends a **1-ml/cc to 30 oz.** warm water solution for disinfecting regulators using a spray bottle.

When using a standard 32-ounce spray bottle:

- Take a standard 5-ml syringe and fill it with 1-ml of bleach.
- Fill the spray bottle with 30-oz of warm water and 1-ml of bleach.
- Mix the solution and you're ready to disinfect the regulators.

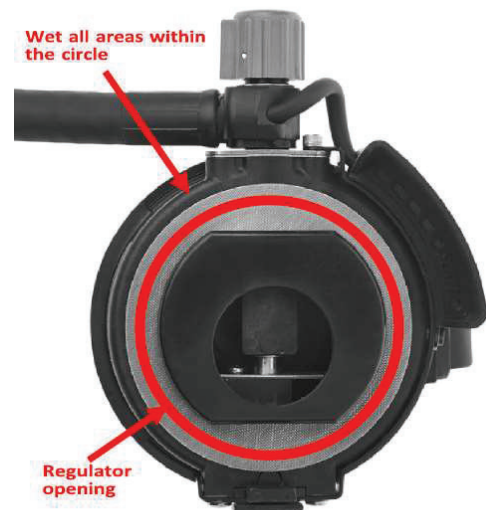


The solution should be left on the regulator for 2-minutes and then rinsed.

Ensure the spray bottles to be compliant with Labor and Industries marking requirements or immediately empty & rinse the un-labeled spray bottle.

### Regulator Cleaning Steps

- Remove the mask-mounted regulator from the facepiece by pulling back on the retaining latch and rotating the regulator one-quarter turn clockwise.
- Using a sponge or soft cloth and the recommended sanitizing or disinfecting cleaner, wipe the external surfaces of the regulator.
- Inspect the inside of the regulator assembly through the regulator opening. If excessive dirt or soil is present, forward the regulator assembly to Scott Safety-trained authorized personnel for thorough cleaning.
- Depress the air-saver/donning switch. Close the purge knob by turning it fully clockwise.
- Using a spray bottle, apply the recommended sanitizing or disinfecting cleaner (1-ml bleach to 30-oz warm water) to the surfaces of the regulator opening and the immediate area



around the opening. Be sure to saturate the internal components completely with the cleaning solution.

- Set the regulator aside for the required contact time prior to rinsing. The 1-ml bleach to 30-oz warm water solution require a 2-minute contact time.
- Using gently running tap water or a spray bottle with drinking water, rinse the regulator inside and out.
- Shake excess water out of regulator. Completely air dry the regulator before use.
  - Note: To speed drying of the regulator, gently blow dry with clean, dry breathing air of 30 psi maximum. Do not use shop air or any other air containing lubricants or moisture.
- If the regulator was disconnected from the air supply for cleaning, reconnect and open the purge valve to remove any moisture from regulator spray bar. Close the purge valve.
- Perform a regulator check after each cleaning.

## Post Response

### Reporting Requirements

During the COVID-19 pandemic there will need to be additional documentation. Thorough documentation will help track the progress of the disease and help us be more proactive with regard to our own safety and the safety of our communities.

- **Station logbooks or EHR tracking:** Used to document the use of PPE on calls with elevated risk.
- **Potential Infectious Disease Exposure Form:** If potential exposure forms are available, they should be used for any exposures considered “Medium” or “High.”
- **ESO:** New sections which pertain to COVID-19 response:
  - All crew members now require specification of what PPE they wear on every call.
    - *Incident tab/Personnel section/PPE drop-down under each name*
  - The Clinical Impression (primary or secondary) now has three COVID-19 related options which will help with tracking:
    - COVID-19 confirmed by testing
    - COVID-19 exposure to confirmed patient
    - COVID-19 suspected – no known exposure
    - *Narrative tab/Impression section/Primary Impression*
  - Under the “Forms” tab there is a box entitled “Outbreak Screening” with questions regarding symptoms and recent contact with other symptomatic people. This form is a requirement for completing any report during the pandemic.
    - Onset of symptoms
    - Symptoms checklist
    - History of illness contact
    - *Forms tab/Outbreak Screening box*

**Non-ESO EHRs may also have COVID-19 tracking systems. Please be familiar with the EHR utilized by your agency.**



## Documentation of Incidents in ESO

### Documentation of Personal Protective Equipment Worn

**Direction:** Required for all EMS incidents, for every crew member, throughout the pandemic. If PPE had been reused (e.g. not a new N95, or a reusable faceshield), document as applicable. This allows accurate tracking of PPE use.

**Location:** Incident tab/Personnel section/each crew member (click “Edit”)

The screenshot shows the ESO software interface. The top navigation bar includes tabs for INCIDENT, PATIENT, VITALS, FLOWCHART, ASSESSMENTS, NARRATIVE, FORMS, BILLING, and SIGNATURES. The 'PERSONNEL' section is active, displaying a list of crew members: AYOTTE, JESSE (PPE (0)), MOORE, ALEXI (PPE (0)), and SCHOENLEBER (PPE (4)). An orange arrow points to the 'PERSONNEL' tab, and another points to the 'Add Crew' button. The 'Personal Protective Equipment' form is open for Ayotte, Jesse, showing a list of PPE items with checkboxes: Ballistic Vest, Eye Protection (checked), Gloves (checked), Gown (checked), Helmet, and Level A Suit. An 'OK' button is visible at the top right of the form.

### Documentation of Clinical Impression

**Direction:** Select one of three COVID-19 options for the primary or secondary impression of the patient's primary problem, when appropriate. Often it will be most appropriate to document the primary impression as the patient's primary problem, with COVID-19 as a secondary impression. This will flag the incident for important review and statistics gathering.

**Location:** Narrative tab/Impression Section/Clinical Impression subsection/Primary of Secondary Impression

The screenshot shows the ESO software interface. The top navigation bar includes tabs for VITALS, FLOWCHART, ASSESSMENTS, NARRATIVE, FORMS, BILLING, and SIGNATURES. The 'NARRATIVE' tab is selected, and the 'Clinical Impression' form is open. The form shows 'Primary Impression' as 'Acute Respiratory Distress (Dyspnea)' and 'Secondary Impression' as 'COVID-19 - Suspected - no known exposure'. A list of COVID-19 options is shown, with 'COVID-19 - Suspected - no known exposure' selected. An orange box highlights the COVID-19 options. The 'OK' button is visible at the top right of the form.

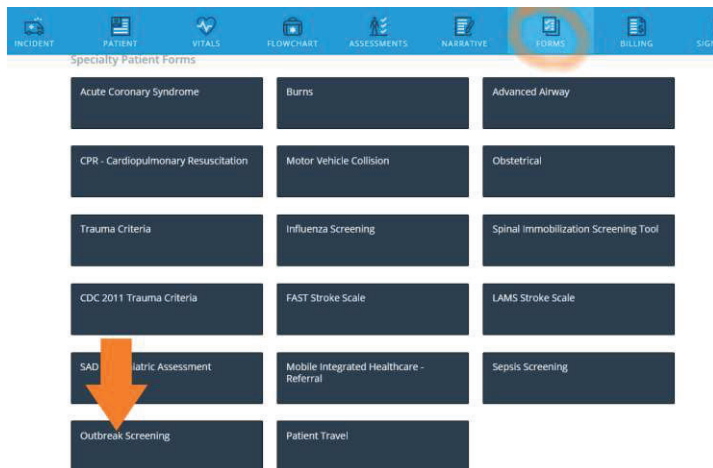
## COVID-19 Response Recommendations

**Documentation of Outbreak Screening**

**Direction:** Required on all EMS incidents throughout the pandemic

**Location:** Forms tab/Outbreak Screening box

A screenshot showing the Outbox Screening box found under the Forms tab is provided below:



Screenshots of the Outbreak Screening form with all symptoms selected are provided below:

Outbreak Screening

☐ UTO
 ☒ OK

Select the outbreak for which you are screening

COVID-19

Onset of Signs and Symptoms

Onset Time

hh:mm:ss

Date

mm/dd/yyyy

Symptoms

Symptoms

Fever, Cough, Sore throat, Shortness of breath, Myalgia/Muscle ache

History

Has the patient traveled outside of the community in the last 30 days?

☐ Yes
 ☐ No

Has the patient traveled outside of the United States in the last 30 days?

☐ Yes
 ☐ No

Has the patient had household or other close contact with someone with the above travel history and symptoms?

☐ Yes
 ☐ No

Has the patient had household or other close contact with someone with a confirmed diagnosis of the illness for which we are screening?

☐ Yes
 ☐ No

Comments

## Exposure

Exposure is thought to occur mostly from person-to-person via respiratory droplets among close contacts.

Close contact with a sick person is generally required to become infected. Close contact includes:

- Living in the same household as a sick person with COVID-19 or a person under investigation,
- Caring for a sick person with COVID-19 or a person under investigation,
- Being within 6 feet of a sick person with COVID-19 or person under investigation for about 10 minutes, OR
- Being in direct contact with secretions from a sick person with COVID-19 or person under investigation (e.g., being coughed on, kissing, sharing utensils, etc.).

If close contact occurs in which a member is not wearing appropriate PPE, or PPE is breached, refer to exposure risk categories.<sup>21</sup>

*If an on duty exposure occurs, follow your agency's infectious exposure policy and contact your POC for further information.*

### High-Risk Exposure

1. Prolonged close contact with an individual with known COVID-19 infection or a person under investigation (PUI) with no patient mask and the provider's nose and mouth is exposed.
2. EMS provider in the room with eyes, nose or mouth unprotected for procedures that generate aerosols or during which respiratory secretions are poorly controlled such as:
  1. Cardiopulmonary resuscitation
    - BVM
    - Intubation
    - CPAP
    - Nebulizer therapy
    - Suctioning

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<sup>21</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

## **Medium-Risk Exposure**

Prolonged close contact with a suspected or known COVID-19 patient, by an EMS provider who is not wearing a facemask, is considered a medium risk exposure. Aerosol generating procedures, without the use of an N95, are also considered medium risk exposures.

## **Low-Risk Exposure**

Low risk exposure generally includes brief interactions with patients with COVID-19 or a person under investigation or prolonged close contact with patients who were wearing a facemask for source control while the EMS provider was wearing a facemask or respirator. Use of eye protection, in addition to a facemask or respirator would further lower the risk of exposure.

## Establishing a Point of Contact

It can be vital to create a point of contact (POC) for members to have a single source of information for COVID-19 related questions and concerns. The inherent nature of this pandemic can cause anxiety and confusion. Giving members a centralized point to report COVID-19 symptoms or exposures can help foster confidence and minimize confusion. Having the point of contact available 24/7 is key to immediately assisting members who become sick.

### Definitions:

**POC:** Point of contact. This can be a single person or an entire team, depending on the needs of the organization. A single point of contact helps streamline communication between members and the organization.

**Hotline:** A 24/7 staffed phone number which can assist members who become sick, or answer questions regarding exposures.

*If there are ANY questions about your crew's safety or ability to respond, first self-isolate affected personnel, then contact supervisor and the Hotline for further information.*

### Potential POC responsibilities:

Member health and welfare should be the primary focus of the point of contact. The purpose of the POC is to answer questions to ensure members remain healthy and assisting them if they become sick. Specifically, potential POC responsibilities include:

**Intake calls:** Answering calls from sick members to assist them with potential isolation procedures, home care needs, paperwork questions, and return to work procedures.

**Answering IAP and procedural questions:** Answering questions regarding PPE guidelines, COVID-19 response plan (IAP) clarifications, and return to work policies. The POC can function as a general resource for members and their families. Members who are sick at home can use the POC as a centralized contact for potential work related illness paperwork. The POC can also help guide sick members through the COVID-19 testing process, if available.

**Tracking of member status:** Ensuring members are supported while they are sick is a key function of the point of contact. Tracking each member while they are in quarantine or isolation, and regularly contacting them regarding their status and needs, can help keep both the agency and the member best informed. The POC can aid in tracking member status as well as anticipated return to work timeframes. This tracking function can provide command staff with real-time staffing information, enabling them to make informed strategic decisions.

## Return to Work Guidelines

### Definitions:

**Symptomatic Member:** Fever  $\geq 100.0^{\circ}$  F, subjective symptoms of fever or respiratory symptoms (cough, sore throat, dyspnea).

**Asymptomatic Exposure:** Members meeting the CDC requirements for low, medium, or high risk exposure to COVID-19, or are otherwise not showing COVID-19 symptoms.

**On-duty Exposure:** Prolonged close contact with a person under investigation or a suspected or known COVID-19 patient without the use of PPE (mask), medium risk exposure, or high-risk exposure.

**Off-duty exposure:** Prolonged close contact with a person under investigation (PUI) or a known COVID-19 patient.

**Travel Exposure:** Members returning from ANY international travel are considered a travel exposure.

**Recovery:** Three days have passed since resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath) **AND** at least 7 days have passed since symptoms first appeared

*Members may experience prolonged cough as a result of respiratory viral infection, which may continue after isolation has ended. Members can be advised to wear a facemask until their cough resolves or their health returns to baseline status.<sup>22</sup>*

**Discontinuing Isolation:** Members may have isolation discontinued and may return to work if they meet the criteria outlined in the **Recovery** definition.

*If new symptoms arise, follow the response recommendations for a **Symptomatic Member**.*

**Positive COVID-19 test or Members Awaiting Test Results:** In order for members to return to work following a positive COVID-19 test, at least 3 days (72 hours) must have passed since recovery **AND** at least **10 days** must have passed since symptoms first appeared. The returning member must ensure they practice respiratory hygiene, hand hygiene, and cough etiquette.

*Isolation increased from 7 days to **10 days** for COVID-19 positive members, or members awaiting test results, per Spokane Regional Health District recommendation.*

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<sup>22</sup> <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/HealthCareworkerReturn2Work.pdf>

## Full Staffing Response Plan:

### Asymptomatic Exposure Work Restrictions:

- For medium and high level exposures while on duty, off duty, or due to travel. Quarantine for 14 days at home or designated quarantine facility.

### Symptomatic Exposure Work Restrictions:

- Complete a COVID-19 test as available. Isolate until 72 hours have passed since recovery **AND** at least **7 days** have passed since symptoms first appeared.
- If not tested, or receive a negative test, isolate until 72 hours have passed since recovery **AND** at least **7 days** have passed since symptoms first appeared.
- Following a positive COVID-19 test, or members awaiting test results, isolate until at least 3 days (72 hours) must have passed since recovery **AND** at least **10 days** must have passed since symptoms first appeared.

*Return to work requires the use of a facemask at all times while at work until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer.<sup>23</sup>*

### Travel Exposure:

- Quarantine and self-monitor (at home, or designated quarantine facility) 14 days from the time the member left the area.<sup>24</sup>

If member develops symptoms of COVID-19 at any time, the member must cease any patient care activities, immediately self-isolate (separate themselves from others), don a facemask (if not already wearing), and notify their supervisor promptly, if on duty.

## Alternate Staffing Response Plan:

*In the event that the number of asymptomatic quarantined personnel compromise the agency's ability to meet public health needs, as determined by the agency, a modified return-to-work strategy approved by the Washington State Department of Health may be enacted.<sup>25</sup>*

### All Masks, All the Time:

In order to protect un-exposed members from exposure to potentially infected but asymptomatic co-workers, all members must wear a facemask, all the time while on shift except while eating, drinking, or sleeping. The asymptomatic, exposed member will wear a facemask as source control, and the unexposed members will wear facemasks as a universal precaution.

<sup>23</sup> <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html>

<sup>24</sup> <https://wwwnc.cdc.gov/travel/notices/warning/coronavirus-europe>

<sup>25</sup> <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/HealthCareworkerReturn2Work.pdf>



**Asymptomatic Exposure:**

- Asymptomatic members with medium or high risk exposure may continue to work provided they adhere to cough etiquette, hand hygiene and wear a facemask at all times while on duty. Members should actively monitor for symptoms consistent with a COVID-19 infection.
- If symptoms of COVID-19 develop at any time, the member must cease patient care activities, immediately self-isolate (separate themselves from others), don a facemask (if not already wearing), and notify their supervisor promptly, if on duty.

**Symptomatic Exposure:**

- Isolate at home, or designated quarantine facility and complete a COVID-19 test as available. If not tested, or receive a negative test, isolate until 72 hours have passed since recovery **AND** at least **7 days** have passed since symptoms first appeared.
- Following a positive COVID-19 test, or members awaiting test results, isolate until at least 3 days (72 hours) must have passed since recovery **AND** at least **10 days** must have passed since symptoms first appeared.<sup>26</sup>
- Returning to work requires the use of a facemask at all times while on shift except while eating, drinking, or sleeping.

**Alternate Staffing Response Plan Summary:**

**If a member is symptomatic:** Symptomatic members will go off duty until they are well.

**On duty:** Immediately self-isolate, don a facemask (if not already wearing), and notify their supervisor.

**Off duty:** Member should contact their agency.

**If a member is asymptomatic:**

- Ensure proper personal protective measures are in place including hygiene, social distancing, and facemask use while on duty.
- Frequently perform self-assessments to monitor for symptoms and document per IAP.
- Continue performing shift duties as normal.

*Adapted from the Washington State Department of Health  
Return to Work Guidance for Health Care Workers and  
First Responders Who Have Confirmed COVID-19 Infection  
Or are Asymptomatic with High or Medium Risk Exposures  
to a Known Case of COVID-19*



<sup>26</sup> <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/HealthCareworkerReturn2Work.pdf>



## Full Staffing Response to COVID-19 Exposure

Epidemiologic risk factors	Exposure category	Work restrictions for an asymptomatic EMS provider
<b>Prolonged close contact with a suspected COVID-19 patient who was wearing a facemask (e.g., source control)</b>		
No provider PPE	Medium	Exclude from work for 14 days after last exposure
Provider not wearing a facemask or respirator	Medium	Exclude from work for 14 days after last exposure
Provider not wearing eye protection	Low	None
Provider not wearing gown or gloves	Low	None
Wearing all recommended PPE	Low	None
<b>Prolonged close contact with a suspected COVID-19 patient who was not wearing a facemask (e.g., no source control)</b>		
No provider PPE	High	Exclude from work for 14 days after last exposure
Provider not wearing a facemask or respirator	High	Exclude from work for 14 days after last exposure
Provider not wearing eye protection	Medium	Exclude from work for 14 days after last exposure
Provider not wearing gown or gloves	Low	None
Wearing all recommended PPE	Low	None

## Alternate Staffing Response to COVID-19 Exposure

Epidemiologic risk factors	Exposure category	Work restrictions for an asymptomatic EMS provider
<b>Prolonged close contact with a suspected COVID-19 patient who was wearing a facemask (e.g., source control)</b>		
No provider PPE	Medium	Continue to work while wearing facemask and practicing proper hygiene and social distancing
Provider not wearing a facemask or respirator	Medium	Continue to work while wearing facemask and practicing proper hygiene and social distancing
Provider not wearing eye protection	Low	None
Provider not wearing gown or gloves	Low	None
Wearing all recommended PPE	Low	None
<b>Prolonged close contact with a suspected COVID-19 patient who was not wearing a facemask (e.g., no source control)</b>		
No provider PPE	High	Continue to work while wearing facemask and practicing proper hygiene and social distancing
Provider not wearing a facemask or respirator	High	Continue to work while wearing facemask and practicing proper hygiene and social distancing
Provider not wearing eye protection	Medium	Continue to work while wearing facemask and practicing proper hygiene and social distancing
Provider not wearing gown or gloves	Low	None
Wearing all recommended PPE	Low	None

## Quarantine and Isolation Recommendations

**Quarantine** is a separation of an *asymptomatic* member who has had prolonged close contact with a person under investigation (PUI) or a suspected or known COVID-19 patient without the use of PPE (mask), or a medium or high-risk exposure. This separation from others who have not been exposed is to prevent possible spread of COVID-19.<sup>27</sup>

### Recommended Procedure:

Members are advised to separate from others, who have not been exposed, through social distancing, and by use of a facemask while working in proximity to other members.

Additional actions include:

- Monitor themselves for signs and symptoms consistent with COVID-19.
- Maintain contact with their agency

**Isolation** is a separation of a *symptomatic* member with a known or suspected COVID-19 infection, from those who have not been infected.

### Recommended Procedure

Members in isolation are to separate themselves from others through social distancing.

Additional precautions include:

- The isolated member should wear a facemask when around other people.
- Full recommended PPE for others coming in contact with the isolated member.
- Prohibit visitors who do not have an essential need to be in the isolation location.
- To the extent possible, members with known or suspected COVID-19 should be housed in an isolated room or area for the duration of their isolation to minimize pathogen spread.
- Other members should stay in another room or be separated from the isolated member as much as possible. Household members should use a separate bedroom and bathroom, if possible.
- Perform hand hygiene frequently.
- Clean all “high-touch” surfaces, such as counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables, every day. Also, clean any surfaces that may have blood, stool, or body fluids on them.
- Avoid sharing household items with the patient. Isolated members should not share dishes, drinking glasses, cups, eating utensils, towels, bedding, or other items. After a member uses these items, they should wash them thoroughly.

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<sup>27</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html>

## Quick Reference Guides

### COVID-19 Screening questions for EMS Providers

#### COVID-19 SCREENING QUESTIONS

1. Do you have a fever?
2. Do you have any symptoms of a fever such as body aches or chills?
3. Do you have a sore throat, cough and/or difficulty breathing?
4. Does anyone here have any of the symptoms I have just asked?
5. Is anyone here under quarantine for any reason?

If YES, or LANGUAGE BARRIER, or UNCONSCIOUS = **LEVEL YELLOW**

If in doubt, err on the side of caution and use an N95.

BVM, CPAP, SVN, Intubation, Suction = **LEVEL RED (N95)** for ALL PERSONNEL

# COVID-19 Response PPE Guide:

COVID-19 Response Recommendations

Follow Your Agency Guidelines Regarding Specific PPE Use

## Level Green

## Level Yellow

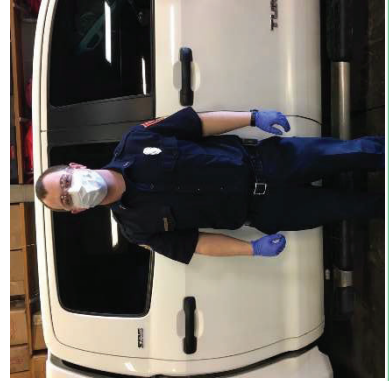
## Level Red

### Minimum PPE

#### All Calls

Don prior to performing a door triage

- Gloves
- Standard Eye Protection
- Facemask



### COVID Response

#### Standard Encounter

Positive Screening from dispatch or door triage

- Gloves
- Standard Eye Protection and Faceshield
- Facemask or N95(+) Respirator
- Gown or Level B



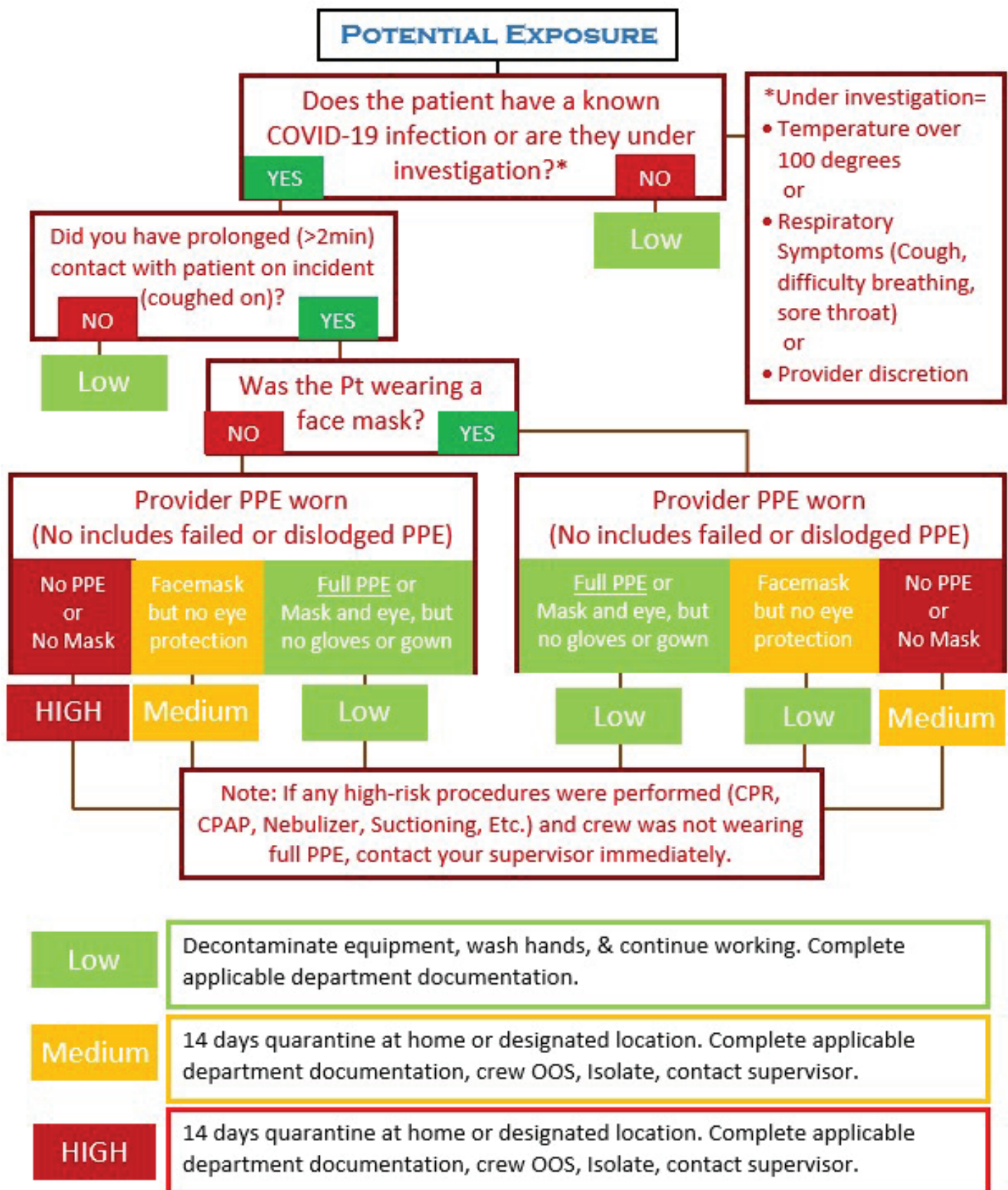
### COVID Response

#### High Risk Encounter

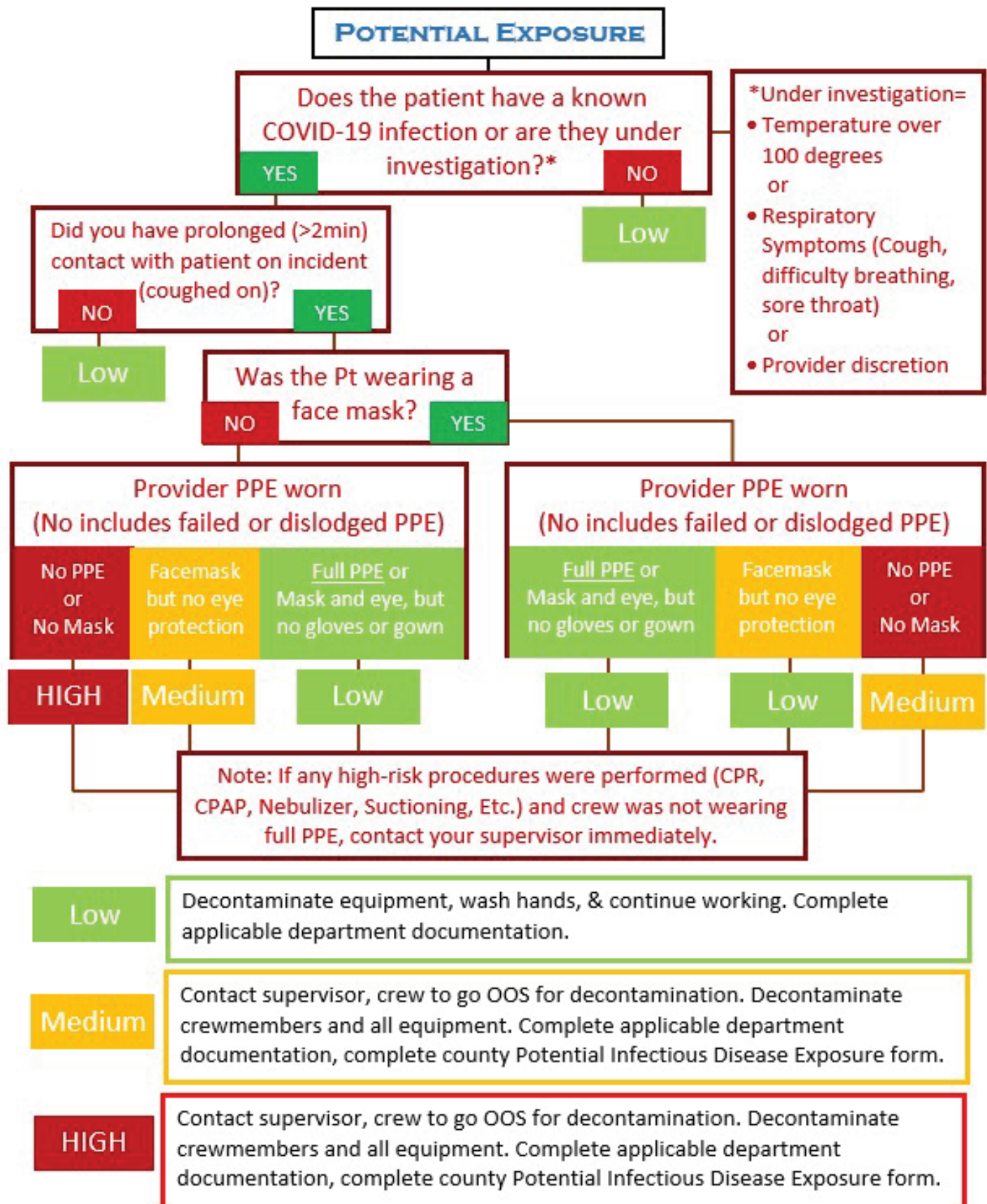
CPR, BVM, Intubation, CPAP, Nebulizer, Suctioning, ETC.

- Gloves
- Standard Eye Protection and Faceshield
- N95(+) Respirator
- Gown or Level B



**EXPOSURE FLOW CHART: FULL STAFFING PLAN**



**EXPOSURE FLOW CHART: ALTERNATE STAFFING PLAN**

# **EXHIBIT 4**



**Spokane Fire Department Guidelines for Continuous Use of Facemasks while On-Duty for All On-Duty Personnel**

Following the department's implementation of the Washington State Department of Health guidelines on 03/21/2020, the Spokane Fire Department is requiring all on-duty personnel to wear a facemask (non-N95) at all times while on duty, with the following exceptions: they may remove the mask while sleeping, eating or drinking (while still maintaining social distancing). Social distancing ( $\geq 6$  foot separation) is still critical, especially during activities which require the removal of the mask.

Our wide variety of emergency responses will occasionally necessitate the use of best judgement to follow this requirement. Utilizing facemasks and social distancing, to the fullest extent practical, helps minimize potential exposure.

This "All Masks, All the Time" requirement helps break the chain-of-exposure to protect you, your crew, your patients, and your family.

According to the CDC, a member maintains a low risk profile in the event another member develops symptoms consistent with COVID-19, provided both members are wearing facemasks. Similarly, prolonged close contact with a presumed or suspected COVID-19 member, who has returned to work, is low risk, provided both members are wearing facemasks. These practices produce a low risk profile; however, diligent cough and hand hygiene will further decrease your risk.

The COVID-19 EMS Response PPE requirements for patient contact have not changed.

In summary, symptomatic members will remain at home, and will return to work following the direction of the COVID-19 Hotline. Asymptomatic members (exposed, non-exposed, or recovered symptomatic) will return to duty and wear a facemask for the entire shift. We are transitioning to this "All Masks, All the Time" model to maintain the lowest risk profile for all of our members.

The COVID-19 Hotline can be reached at (509) 435-7029.

# **EXHIBIT 5**

**From:** [Lopez, Mike](#)  
**To:** [SFD All Stations](#); [SFD EMSQI](#); [SFD Battalion Chiefs](#)  
**Subject:** Friday Noon Vaccine Webinar with Dr. Edminster  
**Date:** Thursday, January 7, 2021 11:15:45 AM  
**Attachments:** [image003.png](#)

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Dr. Edminster is hosting a webinar about the Moderna vaccine in order to provide some information about the vaccine and field questions from those attending. This is scheduled for Friday, January 8, 2021 at noon. Please use the following link to attend this webinar:

<https://spokanecity.webex.com/meet/jedminster>

Thanks and let me know if you have any questions. Take care.

cid:image001.png@01D3C299.2FDA3210



**Mike Lopez,BSN**  
**Office Phone: 509.625.7092**  
**Cell Phone: 509.435.7092**  
**Email: [mlopez@spokanecity.org](mailto:mlopez@spokanecity.org)**

# **EXHIBIT 6**

09/02/2021

Joel D. Edminster, MD, FACEP  
Medical Director SFD/SVFD/SCFD#9  
1618 N Rebecca St.  
Spokane, WA 99217

I have had a number of members contact me to discuss my thoughts on the Covid Vaccines. Specifically, the safety and efficacy of them, as well as my thoughts on the initial emergency authorization use and now the Governor's mandate for mandatory vaccines for healthcare providers. This is a complex topic that has generated a lot of strong opinions. Unfortunately, as is frequently the case in times of chaos, people have used the vaccine as a political and social instrument to promote various agendas rather than as a medical tool for which it was designed. I am personally saddened and disheartened by the divisiveness that I have seen in our nation regarding our general response to the COVID pandemic but that is another topic and not altogether surprising considering the current political environment that our elected officials and media outlets have produced; a perfect storm so-to-speak.

Politics aside, I would like to humbly share some of my thoughts and my position regarding the topics at hand. I hope that my history with you all as educator of medical information, my lectures and trainings will have instilled a foundation of trust and reliability. I fully acknowledge that some of you are firm believers in your present positions and I will not persuade you or convince you to agree with me. My intention is not to influence the few extreme perspectives of the "bell shaped curve" but rather to assist the many of you who make up the bulk of our members and have legitimate concerns and questions and face very difficult decisions in the next several weeks in regard to vaccination mandates and vaccine safety.

I think it is important to be clear on what the purpose and intent is for vaccinations. Vaccines are intended to introduce the host immune system to a potential pathogen (virus, bacteria, etc.) and subsequently initiate an immune response that will help the host mount a robust immune response when they are introduced to that particular pathogen in the future. The coronavirus vaccines generally use the spike protein which is a large protein on the surface of the viral coat as the antigen for developing an immune response and subsequent long term immunity. When people get vaccinated, the host cells, mostly cells at the inoculation site and some immune cells, incorporate the RNA sequence into the ribosome of the cell where the spike protein is synthesized. Contrary to some misinformation that is circulated, the sequence does not get introduced into the nucleus of the cell and does not incorporate into a host's DNA. Most, if not all infected cells become cleared by the host cell's immune response within a matter of days. The most common side effects that people experience are that of the immune response that is generating long term immunity. Fatigue, fever, myalgia, enlarged lymph nodes, etc. There are very few serious side effects which I will address in a moment. The benefit of vaccination is best realized in terms of populations, not individuals. While there is some significant value to the individual in regard to protection from disease the greatest benefit is when herd immunity is attained and the disease of concern is reduced to levels that do not pose a threat to the community. In some cases vaccination programs have eradicated diseases entirely. A recent study from Morbidity and Mortality Weekly suggested that unvaccinated persons are 5x more likely to contract COVID-19 and 29x more likely to be hospitalized for COVID-19. This is a very significant difference and major reason

for hospitals and healthcare providers feeling the strain of the current surge. Vaccination is the safest and best strategy for quelling the current surge and returning to an unrestricted and normal future.

The greatest source of vaccine hesitation that has been expressed to me is in regard to the safety and efficacy of various vaccines, especially the mRNA vaccines. mRNA vaccines have been studied for nearly 10 years with a number of different trials, including vaccines for Zika, SARS, and now Covid-19. Long term safety has been consistently demonstrated and I have no doubt that all of the current US vaccines will receive USDA authorization at the conclusion of their phase 3 trials. There are a number of side effects that have gained some national attention that are recognized as complications although exceedingly rare;

- Thrombosis with Thrombocytopenia Syndrome is a disease of abnormal blood clotting and low platelets. It has been documented in 44 of the 14 Million J&J patients (0.0003%) and 2 of the 346 million mRNA vaccine patients
- Guillain-Barre Syndrome is an ascending paralysis that can last weeks to months. It has been documented in 167 of the 14 Million J&J patients (0.0012%)
- Myocarditis and Pericarditis is inflammation of the heart or pericardium respectively. It has been confirmed in 778 cases associated with the mRNA vaccines (0.00002%)

Based on these statistics and the incidence of fatality and long term sequelae of Covid-19 infection I would argue that the risk-to-benefit ration based on the likelihood of harm from the current vaccines is heavily weighted in favor of vaccination. I would ask you to apply a rational mind to these numbers and consider the much higher risks associated with routine medications and behaviors such as NSAIDS, antibiotics, Alcohol, tobacco, driving, your occupation as firefighters, etc. Nothing is without risk however, at the current rate of COVID infections the decision to remain unvaccinated is without a doubt a greater risk than adverse effects of vaccination.

In regard to mandatory vaccinations for healthcare providers, I see the current requirement of Covid vaccination as a practice that is consistent with current vaccine requirements. Many, if not all of you have been required to have certain vaccinations to enroll in public education, college, work in a healthcare environments, join the military, etc. Mandatory vaccination with rare exemptions is the norm in modern society. Numerous private institutions, including hospitals have required flu vaccinations for employees in the past with some religious and medical exemptions. I am not surprised that the COVID Vaccine is now also one of those requirements and truthfully am more surprised at the perception that this altogether different than any of the other vaccine "mandates" that preceded this current debate. I believe that as health care providers we have a duty and ethical obligation to participate in vaccination programs and I am in full support of Covid Vaccine mandates. This is a shared sentiment of the vast majority of governing bodies that advocate for our various professions including, but not limited to, the American Academy of Emergency Medicine (AAEM), National Association of EMS Physicians (NAEMSP), American Paramedic Association (APA), National EMS Management Association (NEMSMA) American College of Emergency Physicians (ACEP), American Medical Association (AMA), American Hospital Association (AHA), American Academy of Nursing (ANA). A comprehensive list listing the organizations that have participated in this joint position statement is available for review at <https://cmss.org/joint-covid-19-vaccine-mandate>. Additionally, The IAFF position statement regarding this topic reads; "the IAFF strongly recommends all members be vaccinated against the coronavirus for their own protection and the protection of their brothers and sisters, family members, friends and

communities." I would encourage you to read the entire position statement at <https://www.iaff.org/uncategorized/iaff-position-statement-on-covid-19-vaccines>

I know that many of you have been presented a difficult situation that will have social, financial and personal ramifications. I understand that the introduction of a mandate may further galvanize many of you on principle. I would ask that you consider the benefits to a wholehearted community effort to increase the number of vaccinated individuals that we live and work with each day. The science absolutely supports vaccination. The risks, although not zero, are significantly less than the risks associate with COVID-19 infection. I truly believe that we have a duty as healthcare workers, public servants and respected leaders in a times of crisis and chaos to take the lead to make sacrifices for the good of others. A significant number of people that we encounter in emergency medicine and EMS are vulnerable individuals, including the elderly & immunocompromised. We are entrusted to ensure their safety and well-being. Our current pandemic puts this fundamental trust and commitment to safety at risk when we choose not to participate in vaccination programs. If you have questions or hesitations regarding vaccination please feel free to contact me and I will gladly discuss the topic and try to address concerns that you may have.

Respectfully,

A handwritten signature in black ink, consisting of a large, stylized 'J' followed by a horizontal line and a small flourish.

Dr. Joel Edminster

# **EXHIBIT 7**



# Memo

**To:** Chief Brian Schaeffer

**From:** Joel Edminster MD

**Date:** 10/13/2022

**Re:** SARS-CoVID-2 immunity current evidence

---

Current guidelines from the CDC encourage individuals who have had COVID-19 and recovered to get one of the approved COVID-19 vaccinations to better protect against reinfection and possible transmission of COVID-19 (1). The current body of evidence does not ensure that history of prior COVID-19 infection is adequate for long-term personal protection from re-infection with COVID-19 or community protection against progression of the COVID-19 pandemic.

Acquired immunity through natural infection to the SARs-CoVID-2 virus versus immunity achieved through the use of vaccines currently approved for use in the United States has been a frequent topic of discussion and debate in both scientific and public circles. It has become increasingly contentious as the deadline for vaccination mandate for healthcare workers in Washington State approaches. As is the case with any topic that impacts healthcare policy and practice we rely on the body of scientific evidence that exists to ensure that we are making evidence based decisions to effectively mitigate and manage healthcare dilemmas. Understanding that the body of evidence evolves with technological advancements and new evidence, and with the expectation that more studies will undoubtedly emerge over the next months, this is a summary of best evidence for the current recommendations.

We can be reasonably confident that short-term protective immunity is achieved through COVID-19 infection and vaccination as both produce a host immune response. This is consistent with the human immune responses to exposure from a pathogen or vaccine. The duration of the resulting protective immunity achieved by SARs-Cov-2 infection or a vaccine is less clear. Most evidence suggests that immunity from both sources of exposure will wane over time. Most of the prospective evidence has been focused on the vaccine strategy due in large part to the rigorous testing that is inherent to Phase III clinical trials. We still require additional quality studies to study long term immunity as most evidence to date is based on observational data and modeling in comparison to other coronavirus pandemics (SARS, MERS). Additional limitations to understanding and gauging long term immunity and its impact on public health lies

in the lack of evidence to outline what titer levels are adequate for reduced risk of reinfection and subsequent transmission along with the technology to deliver that data on a large scale.

Understanding that the body of knowledge is growing and that we need better evidence to advance practice and policy the following is important to acknowledge:

- 1) Best evidence for long term immunity in vaccinated patients will likely come from current ongoing prospective studies as part of the Phase III trials. To date, the evidence demonstrates excellent protection from infection and more importantly prevention of serious illness and hospitalization in those that do become ill with COVID-19
- 2) Protective immunity from natural infection with SARs-COV-2 and COVID-19 exists, however the degree of protection and duration of immunity is unknown.
- 3) Mixed evidence exists on superiority protection between natural immunity versus vaccine immunity. However, the body of evidence that exists supports immunity from vaccine over natural infection with the greatest immunity in those with natural infection AND vaccination.

Conflicting evidence has complicated the current debate regarding superiority of immune response and the need for vaccination in those previously diagnosed COVID-19. A recent retrospective observational study in pre-print which has yet to be peer reviewed from Israel suggested significantly higher rates of reinfection with the delta variant in those who had received the Pfizer vaccine versus those who had natural immunity from prior infection (1). While this is compelling and definitely adds to our body of evidence it does not address the limitations that exist on testing those with prior infection to determine protective immunity, it is limited to evidence on the delta variant alone and does not address the alternative vaccines available for use in the US. Additionally, equally compelling evidence exists that demonstrates higher rates of reinfection in those with natural immunity over vaccine induced immunity in the United States (2).

Until better evidence exists to drive public health policy and medical guidelines we must make decisions based on the body of knowledge that exists. Most evidence that we do have is observational in nature and the overwhelming interpretation of the current evidence is that we need more well designed, preferably prospective studies to better understand the questions at hand. That being said, current recommendations encourage the broad application of vaccination as the best defense against the current COVID pandemic, even in those who have been previously infected. Until the body of evidence exists to ensure long term immunity from natural infection is non-inferior to vaccine induced immunity and titer assays are readily available to demonstrate protective immunity, prior documentation of COVID-19 should not be an exemption for vaccination.

- 1) [https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html?s\\_cid=11572:vaccine%20after%20covid:sem.ga:p:RG:GM:gen:PTN.Grants:FY21](https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html?s_cid=11572:vaccine%20after%20covid:sem.ga:p:RG:GM:gen:PTN.Grants:FY21)

- 2) Sivan Gazit, Roei Shlezinger, Galit Perez, Roni Lotan, Asaf Peretz, Amir Ben-Tov, Dani Cohen, Khitam Muhsen, Gabriel Chodick, Tal Patalon. Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections medRxiv 2021.
- 3) Cavanaugh AM, Spicer KB, Thoroughman D, Glick C, Winter K. Reduced Risk of Reinfection with SARS-CoV-2 After COVID-19 Vaccination — Kentucky, May–June 2021. MMWR Morb Mortal Wkly Rep 2021;70:1081-1083.

# **EXHIBIT 8**

[HOME \(https://cmss.org/\)](https://cmss.org/)

[CONTACT US \(https://cmss.org/contact-us/\)](https://cmss.org/contact-us/)

[SITEMAP \(https://cmss.org/sitemap/\)](https://cmss.org/sitemap/)

[MEMBER LOGIN \(https://cmss.site-ym.com/\)](https://cmss.site-ym.com/)



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# Joint Statement in Support of COVID-19 Vaccine Mandates for All Workers in Health and Long-Term Care

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CMSS is proud to be a signatory on the following joint statement:

## **Joint Statement in Support of COVID-19 Vaccine Mandates for All Workers in Health and Long-Term Care**

*July 26, 2021*

Due to the recent COVID-19 surge and the availability of safe and effective vaccines, our health care organizations and societies advocate that all health care and long-term care employers require their workers to receive the COVID-19 vaccine. This is the logical fulfillment of the ethical commitment of all health care workers to put patients as well as residents of long-term care facilities first and take all steps necessary to ensure their health and well-being.

Because of highly contagious variants, including the Delta variant, and significant numbers of unvaccinated people, COVID-19 cases, hospitalizations and deaths are once again rising throughout the United States.<sup>1</sup> Vaccination is the primary way to put the pandemic behind us and avoid the return of stringent public health measures.

Unfortunately, many health care and long-term care personnel remain unvaccinated. As we move towards full FDA approval of the currently available vaccines, all health care workers should get vaccinated for their own health, and to protect their colleagues, families, residents of long-term care facilities and patients. This is especially necessary to protect those who are vulnerable, including unvaccinated children and the immunocompromised. Indeed, this is why many health care and long-term care organizations already require vaccinations for influenza, hepatitis B, and pertussis.

***We call for all health care and long-term care employers to require their employees to be vaccinated against COVID-19.***

We stand with the growing number of experts and institutions that support the requirement for universal vaccination of health workers.<sup>2,3</sup> While we recognize some workers cannot be vaccinated because of identified medical reasons and should be exempted from a mandate, they constitute a small minority of all workers. Employers should consider any applicable state laws on a case-by-case basis.

Existing COVID-19 vaccine mandates have proven effective.<sup>4,5</sup> Simultaneously, we recognize the historical mistrust of health care institutions, including among many in our own health care workforce. We must continue to address workers' concerns, engage with marginalized populations, and work with trusted messengers to improve vaccine acceptance.

As the health care community leads the way in requiring vaccines for our employees, we hope all other employers across the country will follow our lead and implement effective policies to encourage vaccination. The health and safety of U.S. workers, families, communities, and the nation depends on it.

### **Council of Medical Specialty Societies (CMSS)**


#### **CO-SIGNATORIES (Listed Alphabetically)**

Academy of Managed Care Pharmacy (AMCP)  
 American Academy of Allergy, Asthma & Immunology (AAAAI)  
 American Academy of Ambulatory Care Nursing (AAACN)  
 American Academy of Child and Adolescent Psychiatry (AACAP)  
 American Academy of Family Physicians (AAFP)  
 American Academy of Nursing (AAN)  
 American Academy of Ophthalmology (AAO)  
 American Academy of PAs (AAPA)  
 American Academy of Pediatrics (AAP)  
 American Association of Clinical Endocrinology (AACE)  
 American Association of Colleges of Pharmacy (AACP)  
 American Association of Neuroscience Nurses (AANN)  
 American College of Clinical Pharmacy (ACCP)  
 American College of Emergency Physicians (ACEP)  
 American College of Physicians (ACP)  
 American College of Preventive Medicine (ACPM)  
 American College of Surgeons (ACS)  
 American Epilepsy Society (AES)  
 American Medical Association (AMA)  
 American Nurses Association (ANA)  
 American Pharmacists Association (APhA)  
 American Psychiatric Association (APA)  
 American Public Health Association (APHA)  
 American Society for Clinical Pathology (ASCP)  
 American Society for Radiation Oncology (ASTRO)  
 American Society of Health-System Pharmacists (ASHP)  
 American Society of Hematology (ASH)  
 American Society of Nephrology (ASN)  
 American Thoracic Society (ATS)  
 Association for Clinical Oncology (ASCO)  
 Association for Professionals in Infection Control and Epidemiology (APIC)  
 Association of Academic Health Centers (AAHC)  
 Association of American Medical Colleges (AAMC)  
 Association of Rehabilitation Nurses (ARN)  
 Council of Medical Specialty Societies (CMSS)  
 HIV Medicine Association  
 Infectious Diseases Society of America (IDSA)  
 LeadingAge

National Association of Indian Nurses of America (NAINA)  
National Association of Pediatric Nurse Practitioners (NAPNAP)  
National Council of State Boards of Nursing (NCSBN)  
National Hispanic Medical Association (NHMA)  
National League for Nursing (NLN)  
National Medical Association (NMA)  
National Pharmaceutical Association (NPhA)  
Nurses Who Vaccinate (NWV)  
Organization for Associate Degree Nursing (OADN)  
Pediatric Infectious Diseases Society (PIDS)  
Philippine Nurses Association of America, Inc (PNAA)  
Society for Healthcare Epidemiology of America (SHEA)  
Society of Critical Care Medicine (SCCM)  
Society of Gynecologic Oncology (SGO)  
Society of Hospital Medicine (SHM)  
Society of Infectious Diseases Pharmacists (SIDP)  
Society of Interventional Radiology (SIR)  
Texas Nurses Association (TNA)  
The John A. Hartford Foundation  
Transcultural Nursing Society (TCNS)  
Virgin Islands State Nurses Association (VISNA)  
Wound, Ostomy, and Continence Nurses Society (WOCN)

1. Centers for Disease Control and Prevention. Covid Data Tracker Weekly Review. July 16, 2021. <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html> (<https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html>) [Accessed 22 July 2021].
  2. Weber, D., Al-Tawfiq, J., Babcock, H., Bryant, K., Drees, M., Elshaboury, R., et al. (2021). Multisociety Statement on COVID-19 Vaccination as a Condition of Employment for Healthcare Personnel. *Infection Control & Hospital Epidemiology*, 1-46. doi:10.1017/ice.2021.322
  3. American Hospital Association. AHA Policy Statement on Mandatory COVID-19 Vaccination of Health Care Personnel. July 21, 2021. <https://www.aha.org/public-comments/2021-07-21-aha-policy-statement-mandatory-covid-19-vaccination-health-care> (<https://www.aha.org/public-comments/2021-07-21-aha-policy-statement-mandatory-covid-19-vaccination-health-care>)
  4. Bacon J. 'Condition of employment': Hospitals in DC, across the nation follow Houston Methodist in requiring vaccination for workers. *USA Today*. Available from: <https://www.usatoday.com/story/news/health/2021/06/10/dc-hospitals-others-follow-houston-methodist-requiring-vaccination/7633481002/> (<https://www.usatoday.com/story/news/health/2021/06/10/dc-hospitals-others-follow-houston-methodist-requiring-vaccination/7633481002/>) [Accessed 22 July 2021].
  5. Paulin E. More Nursing Homes Are Requiring Staff COVID-19 Vaccinations. *AARP*. Available from: <https://www.aarp.org/caregiving/health/info-2021/nursing-homes-covid-vaccine-mandate.html> (<https://www.aarp.org/caregiving/health/info-2021/nursing-homes-covid-vaccine-mandate.html>) [Accessed 22 July 2021].
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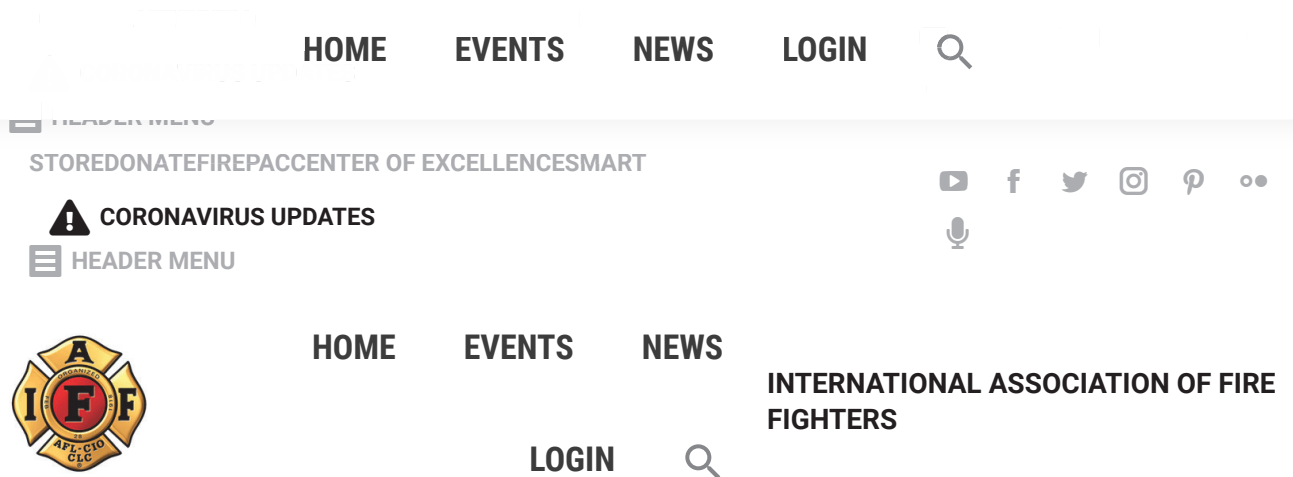
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## **EXHIBIT 9**



## IAFF POSITION STATEMENT ON COVID-19 VACCINES

HOME / UNCATEGORIZED  
/ IAFF POSITION STATEMENT ON COVID-19...



**The IAFF strongly recommends that all IAFF members receive a SARS-CoV-2 (COVID-19) vaccine to prevent the spread of disease and assist in administering vaccinations in jurisdictions where appropriate measures are taken to protect our members health and safety and their rights on the job when vaccinations are being administered, according to the specifications listed below.**

The IAFF strongly recommends all members be vaccinated against the coronavirus (SARS-CoV-2) for their own protection and the protection of their brothers and sisters, family members, friends and communities. It is critical that members are protected through vaccinations to maintain their readiness to respond to COVID-19 and other emergencies, as the number of positive tests, hospitalizations and deaths from COVID-19 continue to rise amidst flu season.

As fire fighters and medical emergency personnel who work in confined and uncontrolled environments while treating or transporting patients or interacting

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The IAFF has urged federal, state and local governments to include fire fighters in Tier 1a for vaccine distribution. In Canada the IAFF has requested the federal government include fire fighters in the same priority group as other healthcare workers.

The Fire Service Joint Labor/Management Wellness-Fitness Initiative (WFI) states, "Uniformed personnel must receive or provide documentation of having received vaccinations." The IAFF and the International Association of Fire Chiefs (IAFC) have collectively embraced and promoted this initiative, and we continue to advocate, educate and recommend the COVID-19 vaccine for our members.

Under the advisement and guidance of our Johns Hopkins University medical team and WFI doctors, along with NFPA 1581 *Standard on Fire Department Infection Control Program* and NFPA 1582, *Standard on Comprehensive Occupational Medical Program for Fire Departments*, **the IAFF urges members to be vaccinated for COVID-19.**

The IAFF recognizes that under some circumstances, including sincere religious objections or a bona fide medical reason, fire fighters may object to being vaccinated. These members may be able to obtain an exemption or reasonable accommodation from their fire departments. The IAFF recommends the following guidelines from the NFPA 1581 Standard:

- 4.5.2.5\* Members who choose to decline immunizations offered by the department shall be required to sign a written declination.
- 4.5.2.5(a) Members who decline immunizations should be counseled by the fire department physician. If the member persists in refusing vaccination, a signed written declination is required.
- 4.5.2.5.1 The declination shall become part of the member's confidential health database.
- 4.5.2.5.2 Members shall be allowed to recant a declination at any time and receive the offered immunizations.

In the event the state, provincial or local government or the fire department mandates the vaccine, members may be subject to penalization of workers' compensation, disability or Public Safety Officers' Benefit (PSOB). An exemption or preferred accommodation may be difficult to obtain through a lawsuit as

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exemption to a COVID-19 vaccination would cause an undue hardship given that public health and safety are at risk.

While vaccines present minimal side effects, no serious safety or health concerns have been reported at the time this position statement was written. The Pfizer and Moderna vaccines are molecular RNA based (not a live virus) and both vaccines have a 95% efficacy rate compared to a 40-60% efficacy rate of the influenza (flu) vaccine and provide antibodies and T-cell immunity against COVID-19.

Additionally, due to the public health crisis and state of emergency, the IAFF supports enlisting fire fighter and emergency medical personnel for vaccine distribution under the following conditions:

- Authorized by state, local or medical directors to provide immunizations
- Compensated at overtime rates as this would be in addition to regular shift work
- Assigning members to provide immunizations does not impact the department's staffing levels for responding to emergencies and performing other duties
- Remain covered through workers' compensation and disability
- Have been vaccinated
- Provided the proper training and education in vaccine handling, tracking and administration
- Provided the proper personal protective equipment (PPE) for vaccine distribution
- A safe environment to distribute the vaccine

The IAFF continues to remain engaged with the incoming Biden-Harris administration to ensure fire fighters are given priority access for PPE, testing and vaccinations at the federal level and seeks help from affiliate leaders in engaging governors and state, provincial and local health departments to ensure members remain a priority at the local level.

The IAFF will provide additional COVID-19 vaccination information developed internally and through the Centers for Disease Control and Prevention (CDC) to

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